

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039957

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9647

STATE FILE NUMBER

FILED OCT 19 1962

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN ST. LOUIS, MO.

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

Inside Limits

Yes ☐ No ☐

c. CITY

OR

TOWN

St. Louis

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #.1

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS

4739 KENSINGTON PL.

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)First
ROBERT

Middle

Last
ASKEN

4. DATE OF DEATH

Month
10-8-62

Day

Year

5. SEX

MALE

6. COLOR OR RACE

Negro

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

8-28-1904

9. AGE (last birthday)

58

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

WATCHMAN

10b. KIND OF BUSINESS OR INDUSTRY

City of St. Louis

11. BIRTHPLACE (City and state or country)

ARK.

12. CITIZEN OF WHAT COUNTRY

U. S. A.

13a. FATHER'S NAME

ALEX ASKEN

13b. MOTHER'S MAIDEN NAME

SALLIE ?

14. NAME OF HUSBAND OR WIFE

INEZ ASKEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of serv)

No.

16. SOCIAL SECURITY NO.

[REDACTED]

17. INFORMANT

INEZ ASKEN - 4739 KENSINGTON PL.

Address

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes☒ No☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

12:15 a.m.

to

10-8-62

and last saw

her

him

alive on

10-8-62

Death occurred at

12:15 a.m.

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

John McLaughlin M.D.

(Degree or title)

22b. ADDRESS

1515 LAFAYETTE AVE

22c. DATE SIGNED

10-8-62

23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

23b. DATE

10-13-62

23c. NAME OF CEMETERY OR CREMATORY

GREENWOOD Cemetery

23d. LOCATION (City, town, or county)

St. Louis, Co., Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

PEOPLES UND. CO. 3100 FRANKLIN AVE

25. DATE RECD. BY LOCAL REG.

OCT 9 1962

26. REGISTRAR'S SIGNATURE

Robert Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

VS 300

Rev. 4/59

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Rev. 4/59

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USE BLACK INK

OR

TYPEWRITER RIBBON

no doneugh

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

H. Claude Raudon

Licensed Embalmer No. 3489

P. O. Address 4500 Newberry, Laramie

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.